Filing at a Glance

Company:	Arkansas Blue Cross and Blue Shield
Product Name:	Amendments
State:	Arkansas
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005C Individual - Other
Filing Type:	Form
Date Submitted:	10/31/2012
SERFF Tr Num:	ARBB-128751567
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	23-2672 1/13
Implementation Date Requested:	01/01/2013
Author(s):	Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	11/01/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Arkansas Blue Cross and Blue Shield*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005C Individual - Other*
Product Name: *Amendments*
Project Name/Number: *2013 General Amendments - Individual/23-2672,23-2673,23-2674,23-2675,23-2676,23-2677,23-2678, 23-2679 1/13*

General Information

Project Name: 2013 General Amendments - Individual
Project Number: 23-2672,23-2673,23-2674,23-2675,23-2676,23-2677,23-2678, 23-2679 1/13
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type:
Overall Rate Impact:

Deemer Date:
Submitted By: Evelyn Laney

Status of Filing in Domicile: Pending
Date Approved in Domicile:

Domicile Status Comments: Arkansas is state of domicile.
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 11/01/2012
State Status Changed: 11/01/2012
Created By: Evelyn Laney
Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null
Include Exchange Intentions: No

Filing Description:
Attached please find forms 23-2672,23-2673,23-2674,23-2675,23-2676,23-2677,23-2678 and 23-2679 1/13 for your review and approval if indicated.

Allowable Charge
We are amending the definition of Charge to clarify that we will pay each Current Procedural Terminology (CPT) code billed only one time. The CPT code is an all-inclusive, global payment that covers all elements of the service as described in the code and paid by the Health Plan. No further reimbursements are allowed. This does not represent a change in benefits.

Dental Care and Orthodontic Services
Generally, dental care and orthodontic services are not covered under the Plan. However, we are amending the provision to allow coverage for dental services in connection with radiation treatment for cancer of the head or neck where appropriate.

Organ Transplant Services
We are amending Plan language to clarify that we cover high-dose or non-myloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation only when supported by the Company's Coverage Policies relative to such conditions. This does not represent a change in benefit but a clarification only.

Influenza Vaccinations
We are modifying the provisions surrounding influenza vaccinations to clarify that coverage is subject to the Plans allowance for intradermally administered (shots) influenza vaccinations without thimerasol. Thimerasol a mercury-containing organic compound that has been widely used as a preservative in many vaccines since the 1930s. This does not represent a change in benefit but a clarification only.

Vision Enhancement
The exclusion for vision enhancements is being amended to reflect new coverage for Keratoprosthesis (corneal implant). It was previously excluded.

Adding a Newborn
[Does not apply to Short-Term Blue or Conversion]

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We have amended our policies to allow a newborn to be added to the policy even if you had "individual only" coverage provided you add the newborn within 90 days of birth. Coverage will become effective on the date of birth if added timely.

Coordination of Benefits
We are adding a coordination of benefits provision to provide for coordination between two Blue Cross and/or Blue Shield policies to prevent over-insurance. This applies only when a covered person has a Short-term Blue policy and another Blue Cross and/or Blue Shield health benefit plan. And we, are correcting Coordination of Benefits in the other policies.

Also enclosed is a Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d). Please also note, we have scored the rider as part of the benefit certificates with which it will be used as provided by Arkansas Code Annotated §23-80-206(e).

By way of this letter, I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.
I certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 are incorporated in the benefit certificates to which this amendment will be attached.
I further certify that the consumer information notice required by Arkansas Code Annotated §23-79-138 is incorporated in the benefit certificates to which this amendment is attached.
Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst
320 West Capitol, Ste 211
Little Rock, AR 72201

exlaney@arkbluecross.com
501-378-2165 [Phone]
501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield
601 S. Gaines Street
Little Rock, AR 72201
(501) 378-2967 ext. [Phone]

CoCode: 83470
Group Code:
Group Name:
FEIN Number: 71-0226428

State of Domicile: Arkansas
Company Type:
State ID Number: N/A

Filing Fees

Fee Required?	Yes
Fee Amount:	$400.00
Retaliatory?	No
Fee Explanation:	$50.00 per form.
Per Company:	No

Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	$400.00	10/31/2012	64440907

SERFF Tracking #:	*ARBB-128751567*	***State Tracking #:***		***Company Tracking #:***	*23-2672 1/13*

State:	*Arkansas*	***Filing Company:***	*Arkansas Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/01/2012	11/01/2012

SERFF Tracking #:	*ARBB-128751567*	***State Tracking #:***		***Company Tracking #:***	*23-2672 1/13*

State:	*Arkansas*	***Filing Company:***	*Arkansas Blue Cross and Blue Shield*
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Disposition

Disposition Date: 11/01/2012
Implementation Date:
Status: Approved-Closed

HHS Status: HHS Approved
State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	23-2672 1/13	Approved-Closed	Yes
Form	23-2673 1/13	Approved-Closed	Yes
Form	23-2674 1/13	Approved-Closed	Yes
Form	23-2675 1/13	Approved-Closed	Yes
Form	23-2676 1/13	Approved-Closed	Yes
Form	23-2677 1/13	Approved-Closed	Yes
Form	23-2678 1/13	Approved-Closed	Yes
Form	23-2679 1/13	Approved-Closed	Yes

SERFF Tracking #: ARBB-128751567 **State Tracking #:** **Company Tracking #:** 23-2672 1/13

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Form Schedule

Lead Form Number: 23-2672 1/13

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/01/2012	23-2672 1/13	Amendment	CERA	Initial		40.600	23-2672 1-13 abcbs Ind. amd(Open-Closed).pdf
2	Approved-Closed 11/01/2012	23-2673 1/13	Amendment	CERA	Initial		40.600	23-2673 1-13 abcbs Ind. amd(Open-Closed).pdf
3	Approved-Closed 11/01/2012	23-2674 1/13	Amendment	CERA	Initial		40.600	23-2674 1-13 abcbs Ind. amd(Open-Closed).pdf
4	Approved-Closed 11/01/2012	23-2675 1/13	Amendment	CERA	Initial		40.600	23-2675 1-13 abcbs Ind. amd(Open-Closed).pdf
5	Approved-Closed 11/01/2012	23-2676 1/13	Amendment	CERA	Initial		40.600	23-2676 1-13 abcbs Ind amd(Open-Closed).pdf
6	Approved-Closed 11/01/2012	23-2677 1/13	Amendment	CERA	Initial		40.600	23-2677 1-13 abcbs Ind amd(Open-Closed).pdf

SERFF Tracking #:	*ARBB-128751567*	***State Tracking #:***		***Company Tracking #:***	*23-2672 1/13*

State:	*Arkansas*	***Filing Company:***	*Arkansas Blue Cross and Blue Shield*
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Lead Form Number: 23-2672 1/13

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
7	Approved-Closed 11/01/2012	23-2678 1/13	Amendment	CERA	Initial		40.600	23-2678 1-13 abcbs Ind. amd(Open-Closed).pdf
8	Approved-Closed 11/01/2012	23-2679 1/13	Amendment	CERA	Initial		40.600	23-2679 1-13 abcbs Ind. amd(Open-Closed).pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO THE ARKANSAS BLUE CROSS AND BLUE SHIELD COMPREHENSIVE MAJOR MEDICAL INDIVIDUAL INSURANCE POLICIES

AMENDMENT NO. 2672
GENERAL AMENDMENT
Form Nos. 69,70,111,113,141,147,148,166

The notice below regarding Medical Loss Ratio Information is required by the federal government. This notice is for members who did not receive a rebate because their segment of the market had a medical loss ratio higher than the minimum required by the Affordable Care Act.

"Medical Loss Ratio Information - The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov."

The following subsection amendments are effective on January 1, 2013.

DEFINITIONS, " **Charge**" is hereby amended to read as follows.

Charge, when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Charge. However, Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See ARTICLE XII., Q. dealing with Out of Arkansas Claims. See ARTICLE V., W.5. with respect to Charge for transplants. See ARTICLE IV., A. with respect to Charge for Outpatient Surgery Centers. **Please note that all benefits under this Policy are subject to and shall be paid only by reference to the**

Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Charge.

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can

protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

HOSPITAL BENEFITS, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

HOSPITAL BENEFITS, Limitations of Hospital Benefits, C.2 is hereby amended to read as follows.

The Company will pay for Complications of Pregnancy. The Company will pay routine nursery Charges for well baby care for a period of up to five (5) days or until the mother is discharged, (whichever is the lesser period). Coverage for the Policyholder's newborn Child shall become effective as of the Child's date of birth if the Policyholder gives the Company notice by submitting an application or change form to the Company for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid.

OUTPATIENT CARE, is amended by the adding the following notice.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Payment as set out in "OTHER PROVISIONS, and the Schedule of Benefits.

OTHER COVERED MEDICAL EXPENSES, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

> **You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.**

OTHER COVERED MEDICAL EXPENSES, "Organ Transplant Services" Subsections 8-10 are hereby amended to read as follows.

8. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.

OTHER COVERED MEDICAL EXPENSES, children's preventive health care services, Subsection 4 is hereby amended to read as follows.

> Subject to the Covered Person's payment of the Deductible and the appropriate Coinsurance set forth in the Schedule of Benefits, the Company will pay the percentage set forth on the Schedule of Benefits of Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. Benefits for Evaluation and Management Office Visits and recommended immunization services shall be exempt from any copayment, Coinsurance, Deductible or dollar limit provisions. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

OTHER COVERED MEDICAL EXPENSES, Adult Immunizations is hereby amended to read as follows.

> Adult Immunizations. Adult immunizations are generally not covered unless this Policy includes coverage for wellness. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for influenza immunizations for Covered Persons age 18 and older if administered by a Provider whose scope of practice includes administration of vaccines. Influenza immunizations are exempt from any copayment, Deductible or Coinsurance obligations but are limited to the Charge as determined by the Company. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

SERVICES NOT INCLUDED, "Dental Care and Orthodontic Services" is hereby amended to read as follows.

> **Dental Care and Orthodontic Services.** Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:
>
> 1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
> 2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.

3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures are generally not covered. However, some services may be covered in accordance with “HOSPITAL BENEFITS” and “OUTPATIENT CARE.”

SERVICES NOT INCLUDED, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

COORDINATION WITH GROUP COVERAGE, MAJOR MEDICAL COVERAGE AND MEDICARE is hereby amended to read as follows.

If any benefits for services or supplies under this Policy are available to you under any group or blanket disability insurance, Union Welfare Plan, employer or employee benefit organization, self insurance or any other non-regulated group disability benefit plan, individual major medical Policy or no-fault automobile liability insurance, coverages will be coordinated. In other words, benefits may not exceed one hundred percent (100%) of eligible benefits under the combined coverages. The order of benefit determination shall be as follows:

A. The coverage of the Policyholder who is the patient is primary.
B. The coverage of your non-employed Spouse who is also the patient is primary.
C. If your dependent other than your Spouse is the patient, the coverage of the parent whose birthday is first in the year is primary.
D. If the birthdays are the same, the coverage with the earliest effective date is primary.
E. If the parents are separated or divorced, the coverage of the parent who has, in fact, assumed financial responsibility for the dependent, is primary.

OTHER PROVISIONS, is hereby amended to add the following provision.

Scope of Provider Payment - Global Payment. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs)

associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO THE ARKANSAS BLUE CROSS AND BLUE SHIELD COMPREHENSIVE MAJOR MEDICAL INDIVIDUAL INSURANCE POLICIES

AMENDMENT NO. 2673
GENERAL AMENDMENT
Form No. 108

The notice below regarding Medical Loss Ratio Information is required by the federal government. This notice is for members who did not receive a rebate because their segment of the market had a medical loss ratio higher than the minimum required by the Affordable Care Act.

"Medical Loss Ratio Information - The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov."

The following subsection amendments are effective on January 1, 2013.

DEFINITIONS, " **Charge**" is hereby amended to read as follows.

Charge**,** when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Charge. However, Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See ARTICLE XI., P. dealing with Out of Arkansas Claims. See ARTICLE V., P.5. with respect to Charge for transplants. See ARTICLE IV., A. with respect to Charge for Outpatient Surgery Centers. **Please note that all**

benefits under this Policy are subject to and shall be paid only by reference to the Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Charge.

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among

themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

HOSPITAL BENEFITS, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

HOSPITAL BENEFITS, Limitation of Hospital Benefits, C.3 is hereby amended to read as follows.

The Company will pay for Complications of Pregnancy. The Company will pay routine nursery Charges for well baby care for a period of up to five (5) days or until the mother is discharged, (whichever is the lesser period). Coverage for the Policyholder's newborn Child shall become effective as of the Child's date of birth if the Policyholder gives the Company notice by submitting an application or change form to the Company for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid.

OUTPATIENT CARE, is amended by the adding the following notice.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

COVERED MEDICAL EXPENSES, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

COVERED MEDICAL EXPENSES, "Organ Transplant Services" Subsections 8-10 are hereby amended to read as follows.

8. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.

COVERED MEDICAL EXPENSES, children's preventive health services**,** Subsection 4 is hereby amended to read as follows.

Subject to the Covered Person's payment of the Deductible and the appropriate Coinsurance set forth in the Schedule of Benefits, the Company will pay the percentage set forth on the Schedule of Benefits of Allowable Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. Benefits for Evaluation and Management Office Visits and recommended immunization services shall be exempt from any copayment, Coinsurance, Deductible or dollar limit provisions. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

COVERED MEDICAL EXPENSES, Adult Immunizations is hereby amended to read as follows.

Adult Immunizations. Adult immunizations are generally not covered unless this Policy includes coverage for wellness. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for influenza immunizations for Covered Persons age 18 and older if administered by a Provider whose scope of practice includes administration of vaccines. Influenza immunizations are exempt from any copayment, Deductible or Coinsurance obligations but are limited to the Allowable Charge as determined by the Company. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

SERVICES NOT INCLUDED, "Dental Care and Orthodontic Services" is hereby amended to read as follows.

Dental Care and Orthodontic Services. Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:

1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.

3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SERVICES NOT INCLUDED, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

OTHER PROVISIONS, is hereby amended to add the following provision.

Scope of Provider Payment - Global Payment. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or

treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
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An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO THE ARKANSAS BLUE CROSS AND BLUE SHIELD COMPREHENSIVE MAJOR MEDICAL INDIVIDUAL INSURANCE POLICIES

AMENDMENT NO. 2674
GENERAL AMENDMENT
Form No. 213

The notice below regarding Medical Loss Ratio Information is required by the federal government. This notice is for members who did not receive a rebate because their segment of the market had a medical loss ratio higher than the minimum required by the Affordable Care Act.

"Medical Loss Ratio Information - The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov."

The following subsection amendments are effective on January 1, 2013.

DEDINITIONS, "Allowable Charge" is hereby amended to read as follows.

Allowable Charge, when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Allowable Charge. However, Allowable Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See ARTICLE XII., R. dealing with Out of Arkansas Claims. See ARTICLE VII. Catastrophic Major Medical Benefit

with respect to Allowable Charge for transplants. See ARTICLE IV. B. with respect to Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Policy are subject to and shall be paid only by reference to the Allowable Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Allowable Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers

involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

INPATIENT HOSPITAL BENEFITS, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

INPATIENT HOSPITAL BENEFITS, IMPORTANT NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

INPATIENT HOSPITAL BENEFITS, Limitation of Hospital Benefits, C.7 is hereby amended to read as follows.

The Company will pay routine nursery Charges for well baby care for a period of up to five (5) days or until the mother is discharged, (whichever is the lesser period). Coverage for the Policyholder's newborn Child shall become effective as of the Child's date of birth if the Policyholder gives the Company notice by submitting an application or change form to the Company for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid.

OUTPATIENT HOSPITAL CARE, IMPORTANT NOTICE, is hereby amended to add the following notice.

> **You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.**

PHYSICIAN SERVICES IN A HOSPITAL, IMPORTANT NOTICE, is hereby amended to add the following paragraph.

> **You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.**

OTHER COVERED MEDICAL EXPENSES, IMPORTANT NOTICE, is hereby amended to add the following paragraph.

> **You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.**

OTHER COVERED MEDICAL EXPENSES, Adult Immunizations is hereby amended to read as follows.

> **Adult Immunizations.** Adult immunizations are generally not covered unless this Policy includes coverage for wellness. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for influenza immunizations for Covered Persons age 18 and older if administered by a Provider whose scope of practice includes administration of vaccines. Influenza immunizations are exempt from any copayment, Deductible or Coinsurance obligations but are limited to the Allowable Charge as determined by the Company. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

CATASTROPHIC MAJOR MEDICAL EXPENSES, IMPORTANT NOTICE, is hereby amended to add the following paragraph.

> **You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.**

CATASTROPHIC MAJOR MEDICAL EXPENSES, "Organ Transplant Services" Subsections h.-l. are hereby amended to read as follows.

h. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.

SERVICES NOT INCLUDED, "Dental Care and Orthodontic Services" is hereby amended to read as follows.

Dental Care and Orthodontic Services. Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:

1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SERVICES NOT INCLUDED, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

OTHER PROVISIONS is hereby amended to add the following provision.

Scope of Provider Payment - Global Payment. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company’s payment to the billing Provider of the Allowable

Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs

divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO THE ARKANSAS BLUE CROSS AND BLUE SHIELD COMPREHENSIVE MAJOR MEDICAL INDIVIDUAL INSURANCE POLICIES

AMENDMENT NO. 2675
GENERAL AMENDMENT
Form Nos. 125,126,129,130

The notice below regarding Medical Loss Ratio Information is required by the federal government. This notice is for members who did not receive a rebate because their segment of the market had a medical loss ratio higher than the minimum required by the Affordable Care Act.

"Medical Loss Ratio Information - The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov."

The following subsection amendments are effective on January 1, 2013.

Charge, when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Charge. However, Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See ARTICLE XIII., R.. dealing with Out of Arkansas Claims. See ARTICLE IV. U.5. with respect to Charge for transplants. See ARTICLE III., A. dealing with out of state Outpatient Surgery Centers. **Please note that all benefits under this Policy are subject to and shall be paid only by reference to the Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This**

means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Charge.

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these

circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

HOSPITAL BENEFITS, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of–Network Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

HOSPITAL BENEFITS, Limitations of Hospital Benefits, C.2 is hereby amended to read as follows.

The Company will pay for Complications of Pregnancy. The Company will pay routine nursery Charges for well baby care for a period of up to five (5) days or until the mother is discharged, (whichever is the lesser period). Coverage for the Policyholder's newborn Child shall become effective as of the Child's date of birth if the Policyholder gives the Company notice by submitting an application or change form to the Company for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid.

OUTPATIENT CARE, is amended by the adding the following notice.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of–Network Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OTHER COVERED MEDICAL EXPENSES, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of–Network Provider, refer to the definition of Charge as set

out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OTHER COVERED MEDICAL EXPENSES, "Organ Transplant Services" Subsections 8-10 are hereby amended to read as follows.

8. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.

OTHER COVERED MEDICAL EXPENSES, children's preventive health care services, Subsection 4 is hereby amended to read as follows.

Subject to the Covered Person's payment of the Deductible and the appropriate Coinsurance set forth in the Schedule of Benefits, the Company will pay the percentage set forth on the Schedule of Benefits of Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. Benefits for Evaluation and Management Office Visits and recommended immunization services shall be exempt from any copayment, Coinsurance, Deductible or dollar limit provisions. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

OTHER COVERED MEDICAL EXPENSES, Adult Immunizations is hereby amended to read as follows.

Adult Immunizations. Adult immunizations are generally not covered unless this Policy includes coverage for wellness. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for influenza immunizations for Covered Persons age 18 and older if administered by a Provider whose scope of practice includes administration of vaccines. Influenza immunizations are exempt from any copayment, Deductible or Coinsurance obligations but are limited to the Charge as determined by the Company. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

SERVICES NOT INCLUDED, "Dental Care and Orthodontic Services" is hereby amended to read as follows.

Dental Care and Orthodontic Services. Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:

1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided

within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.

4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures are generally not covered. However, some services may be covered in accordance ARTICLE II, C. 11. and ARTICLE III, A. 2.

SERVICES NOT INCLUDED, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

COORDINATION AGAINST GROUP COVERAGE, MAJOR MEDICAL COVERAGE AND MEDICARE is hereby amended to read as follows.

If any benefits for services or supplies under this Policy are available to you under any group or blanket disability insurance, Union Welfare Plan, employer or employee benefit organization, self insurance or any other non-regulated group disability benefit plan, individual major medical Policy or no-fault automobile liability insurance, coverages will be coordinated. In other words, benefits may not exceed one hundred percent (100%) of eligible benefits under the combined coverages. The order of benefit determination shall be as follows:

A. The coverage of the Policyholder who is the patient is primary.
B. The coverage of your non-employed Spouse who is also the patient is primary.
C. If your dependent other than your Spouse is the patient, the coverage of the parent whose birthday is first in the year is primary.
D. If the birthdays are the same, the coverage with the earliest effective date is primary.
E. If the parents are separated or divorced, the coverage of the parent who has, in fact, assumed financial responsibility for the dependent, is primary.

OTHER PROVISIONS, is hereby amended to add the following provision.

Scope of Provider Payment - Global Payment. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that

may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will

recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO THE
ARKANSAS BLUE CROSS AND BLUE SHIELD
COMPREHENSIVE MAJOR MEDICAL
INDIVIDUAL INSURANCE POLICIES

AMENDMENT NO. 2676
GENERAL AMENDMENT
Form No. 231

The notice below regarding Medical Loss Ratio Information is required by the federal government. This notice is for members who did not receive a rebate because their segment of the market had a medical loss ratio higher than the minimum required by the Affordable Care Act.

"Medical Loss Ratio Information - The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov."

The following subsection amendments are effective on January 1, 2013.

Face page is hereby amended to add the following notice.

OTHER INSURANCE REDUCES BENEFITS - READ CAREFULLY

DEFINITIONS, " **Charge**" is hereby amended to read as follows.

Charge, when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Charge. However, Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See ARTICLE XII., o.. dealing with Out of Arkansas Claims. See ARTICLE IV., A. with respect to Charge for Outpatient Surgery Centers. **Please note that all benefits under this Policy are subject to and shall be paid only by reference to the Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or

HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

HOSPITAL BENEFITS, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of–Network Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OUTPATIENT CARE, is amended by the adding the following notice.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of–Network Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OTHER COVERED MEDICAL EXPENSES, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of–Network Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OTHER COVERED MEDICAL EXPENSES, children's preventive health care services, Subsection 4 is hereby amended to read as follows.

Subject to the Covered Person's payment of the Deductible and the appropriate Coinsurance set forth in the Schedule of Benefits, the Company will pay the percentage set forth on the Schedule of Benefits of Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. Benefits for Evaluation and Management Office Visits and recommended immunization services shall be exempt from any copayment, Coinsurance, Deductible or dollar limit provisions. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

OTHER COVERED MEDICAL EXPENSES, Adult Immunizations is hereby amended to read as follows.

Adult Immunizations. Adult immunizations are generally not covered unless this Policy includes coverage for wellness. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for influenza immunizations for Covered Persons age 18 and older if administered by a Provider whose scope of practice includes administration of vaccines. Influenza immunizations are exempt from any copayment, Deductible or Coinsurance obligations but are limited to the Charge as determined by the Company. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

SERVICES NOT INCLUDED, "Dental Care and Orthodontic Services" is hereby amended to read as follows.

Dental Care and Orthodontic Services. Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:

1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures are generally not covered. However, some services may be covered in accordance with ARTICLE III, C. 9. and ARTICLE IV, A. 2.

SERVICES NOT INCLUDED, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

This Policy is amended to add the following new ARTICLE XIV entitled "**COORDINATION OF BENEFITS**".

Coordination of Benefits (COB) applies when a Covered Person becomes covered under more than one Blue Cross and/or Blue Shield Health Benefit Plan. The Company may request that a Covered Person verify the existence of other coverage.

A. **Definitions.** For purposes of this provision only, the following words and phrases shall have the following meanings:

1. "Allowable Expenses" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Blue Cross and/or Blue Shield Health Benefit Plans covering the person for whom claim is made. When a Health Benefit Plan provides benefits in the form of coverage for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.
2. "Health Benefit Plan" means any of the following which provide coverage for medical care or treatment:
   a. Group Blue Cross and/or Blue Shield coverage or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including health maintenance organization or other form of group Blue Cross and/or Blue Shield coverage;
   b An individual Blue Cross and/or Blue Shield accident and health insurance policy which reduces benefits because of the existence of other insurance.

   The term "Health Benefit Plan" shall be construed separately with respect to:
   (i) Each Policy, contract or other arrangement for benefits or services.
   (ii) That portion of any such Policy, contract or other arrangement which reserves the right to take the benefits of other Health Benefit Plans into consideration in determining its benefits and that portion which does not.

B. The Company shall have the right to coordinate benefits between this Plan and any other Blue Cross and/or Blue Shield Health Benefit Plan covering a Covered Person.

The rules establishing the order of benefit determination between this Policy and any other Blue Cross and/or Blue Shield Health Benefit Plan covering the Covered Person on whose behalf a claim is made are as follows:

1. The benefits of a Blue Cross and/or Blue Shield Health Benefit Plan which does not have a "coordination of benefits with other health plans" provision shall in all cases be determined and applied to claims before the benefits of this Policy.

2. If according to the rules set forth in Subsection C. of this Section, the benefits of another Blue Cross and/or Blue Shield Health Benefit Plan that contains a provision coordinating its benefits with this Plan would be determined and applied, before the benefits of this Plan have been determined and applied, the benefits of such other Blue Cross and/or Blue Shield Health Benefit Plan will be considered before the determination of benefits under this Plan.

3. Under no circumstances shall benefits payable and paid under this Plan together with any other Blue Cross and/or Blue Shield Health Benefit Plan exceed the total charge for services a Covered Person received.

C. **Order of Benefit Determination:** The order of benefit determination as to a Covered Person's claim shall be as follows:

1. **Non-Dependent or Dependent.** The benefits of a plan which covers the person on whose expenses a claim is based other than as a dependent shall be determined and applied before the benefits of a plan which covers such person as a dependent. (By way of example only, if one Plan [Plan A] covers a person as a Policyholder or an employee and the other plan covers the person as a dependent of a Policyholder or of an employee [Plan B], then Plan A is deemed “primary” and Plan A’s benefits will be applied and paid before any consideration of Plan B.)

2. **Child Covered Under More Than One Plan.** When the parents of a dependent child are married, the benefits of a plan which covers the person on whose expenses a claim is based as a dependent child of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent child of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If the other plan does not have the provisions of this paragraph regarding coverage of dependent children of married parents, or if both parents have the same birthday, the plan that has covered either of the parents longer is primary.

   The following rules apply to determine the order of benefit determination for a dependent child of parents who are separated or divorced:

   a. When the parents are separated or divorced and there is a court decree which fixes financial responsibility on one of the parents for the medical, dental, or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

   b. When the parents are separated or divorced and the parent with custody of the child has not remarried, if there is no court decree fixing financial responsibility on one of the parents for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

   c. When the parents are divorced and the parent with custody of the child has remarried, if there is no court decree fixing financial responsibility on one parent for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

3. **Active or Inactive Employee.** When paragraphs (1) or (2) above do not apply so as to establish an order of benefits determination, the plan that covers a

person as an Policyholder who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and a Policyholder. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule set out in paragraph (1) above.

4. **Continuation coverage.** When paragraphs (1), (2) or (3) above do not apply so as to establish an order of benefits determination, if a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber policyholder or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage.** When paragraphs (1), (2), (3) or (4) above do not apply so as to establish an order of benefits determination, the plan that covered the person as an employee, policyholder, member, subscriber or retiree longer is primary.

6 If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of health benefit plan, Subsection A.2. In addition, this plan will not pay more than it would have paid had it been primary.

OTHER PROVISIONS, is hereby amended to add the following provision.

Scope of Provider Payment - Global Payment. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a

single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO THE ARKANSAS BLUE CROSS AND BLUE SHIELD COMPREHENSIVE MAJOR MEDICAL INDIVIDUAL INSURANCE POLICIES

AMENDMENT NO. 2677
GENERAL AMENDMENT
Form No. 277

The notice below regarding Medical Loss Ratio Information is required by the federal government. This notice is for members who did not receive a rebate because their segment of the market had a medical loss ratio higher than the minimum required by the Affordable Care Act.

"Medical Loss Ratio Information - The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov."

The following subsection amendments are effective on January 1, 2013.

DEFINITIONS, " **Charge**" is hereby amended to read as follows.

Charge, when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Charge. However, Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See ARTICLE XV., A. dealing with Out of Arkansas Claims. See ARTICLE VIII., W.5. with respect to Charge for transplants. See ARTICLE VII., A. with respect to Charge for Outpatient Surgery Centers. **Please note that all**

benefits under this Policy are subject to and shall be paid only by reference to the Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Charge.

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among

themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

HOSPITAL BENEFITS, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OUTPATIENT CARE, is amended by the adding the following notice.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OTHER COVERED MEDICAL EXPENSES, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OTHER COVERED MEDICAL EXPENSES, "Organ Transplant Services" Subsections 7-9 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is

provided subject to the Company's specific Coverage Policies relative to these specific conditions.

OTHER COVERED MEDICAL EXPENSES, children's preventive health care services, Subsection 4. is hereby amended to read as follows.

The Company will pay one hundred percent (100%) of Allowable Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

SERVICES NOT INCLUDED, "Dental Care and Orthodontic Services" is hereby amended to read as follows.

Dental Care and Orthodontic Services. Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:

1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures are generally not covered. However, some services may be covered in accordance with ARTICLE II., C. 11. and ARTICLE IV, A. 2.

SERVICES NOT INCLUDED, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or

corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

OTHER PROVISIONS, is hereby amended to add the following provision.

Scope of Provider Payment - Global Payment. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these

circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient.

In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
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Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO THE ARKANSAS BLUE CROSS AND BLUE SHIELD COMPREHENSIVE MAJOR MEDICAL INDIVIDUAL INSURANCE POLICIES

AMENDMENT NO. 2678
GENERAL AMENDMENT
Form Nos. 134,135

The notice below regarding Medical Loss Ratio Information is required by the federal government. This notice is for members who did not receive a rebate because their segment of the market had a medical loss ratio higher than the minimum required by the Affordable Care Act.

"Medical Loss Ratio Information - The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov."

The following subsection amendments are effective on January 1, 2013.

DEFINITIONS, " **Charge**" is hereby amended to read as follows.

Charge, when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Charge. However, Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See ARTICLE XII., P. dealing with Out of Arkansas Claims. See ARTICLE IV., U.5. with respect to Charge for transplants. See ARTICLE III., A. with respect to Charge for Outpatient Surgery Centers. **Please note that all benefits under this Policy are subject to and shall be paid only by reference to the**

Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Charge.

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can

protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

HOSPITAL BENEFITS, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

HOSPITAL BENEFITS, Limitations of Hospital Benefits, C.2 is hereby amended to read as follows.

The Company will pay for Complications of Pregnancy. The Company will pay routine nursery Charges for well baby care for a period of up to five (5) days or until the mother is discharged, (whichever is the lesser period). Coverage for the Policyholder's newborn Child shall become effective as of the Child's date of birth if the Policyholder gives the Company notice by submitting an application or change form to the Company for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid.

OUTPATIENT CARE, is amended by the adding the following notice.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OTHER COVERED MEDICAL EXPENSES, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

> **You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select a Contracting or Non-Contracting Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.**

OTHER COVERED MEDICAL EXPENSES, "Organ Transplant Services" Subsections 8-10 are hereby amended to read as follows.

8. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.

OTHER COVERED MEDICAL EXPENSES, children's preventive health care services, Subsection 4. is hereby amended to read as follows.

> Subject to the Covered Person's payment of the Deductible and the appropriate Coinsurance set forth in the Schedule of Benefits, the Company will pay the percentage set forth on the Schedule of Benefits of Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. Benefits for Evaluation and Management Office Visits and recommended immunization services shall be exempt from any copayment, Coinsurance, Deductible or dollar limit provisions. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

OTHER COVERED MEDICAL EXPENSES, Adult Immunizations is hereby amended to read as follows.

> **Adult Immunizations.** Adult immunizations are generally not covered unless this Policy includes coverage for wellness. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for influenza immunizations for Covered Persons age 18 and older if administered by a Provider whose scope of practice includes administration of vaccines. Influenza immunizations are exempt from any copayment, Deductible or Coinsurance obligations but are limited to the Charge as determined by the Company. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

SERVICES NOT INCLUDED, "Dental Care and Orthodontic Services" is hereby amended to read as follows.

> **Dental Care and Orthodontic Services.** Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:
>
> 1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
> 2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
> 3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental

Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.

4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures are generally not covered. However, some services may be covered in accordance with ARTICLE II., C. 11. and ARTICLE III, A. 2.

SERVICES NOT INCLUDED, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

COORDINATION AGAINST GROUP COVERAGE, MAJOR MEDICAL COVERAGE AND MEDICARE is hereby amended to read as follows.

If any benefits for services or supplies under this Policy are available to you under any group or blanket disability insurance, Union Welfare Plan, employer or employee benefit organization, self insurance or any other non-regulated group disability benefit plan, individual major medical Policy or no-fault automobile liability insurance, coverages will be coordinated. In other words, benefits may not exceed one hundred percent (100%) of eligible benefits under the combined coverages. The order of benefit determination shall be as follows:

A. The coverage of the Policyholder who is the patient is primary.
B. The coverage of your non-employed Spouse who is also the patient is primary.
C. If your dependent other than your Spouse is the patient, the coverage of the parent whose birthday is first in the year is primary.
D. If the birthdays are the same, the coverage with the earliest effective date is primary.
E. If the parents are separated or divorced, the coverage of the parent who has, in fact, assumed financial responsibility for the dependent, is primary.

OTHER PROVISIONS, is hereby amended to add the following provision.

Scope of Provider Payment - Global Payment. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the

Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Contracting Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and

defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO THE ARKANSAS BLUE CROSS AND BLUE SHIELD COMPREHENSIVE MAJOR MEDICAL INDIVIDUAL INSURANCE POLICIES

AMENDMENT NO. 2679
GENERAL AMENDMENT
Form Nos. 183,184

The notice below regarding Medical Loss Ratio Information is required by the federal government. This notice is for members who did not receive a rebate because their segment of the market had a medical loss ratio higher than the minimum required by the Affordable Care Act.

"Medical Loss Ratio Information - The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov."

The following subsection amendments are effective on January 1, 2013.

DEFINITIONS, " **Charge**" is hereby amended to read as follows.

Charge, when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Charge. However, Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See ARTICLE XV., Q. dealing with Out of Arkansas Claims. See ARTICLE V., U.5. with respect to Charge for transplants. See ARTICLE IV., A. with respect to Charge for Outpatient Surgery Centers. **Please note that all benefits under this Policy are subject to and shall be paid only by reference to the**

Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Charge.

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can

protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

HOSPITAL BENEFITS, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of–Network Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

HOSPITAL BENEFITS, Limitations of Hospital Benefits, C.2 is hereby amended to read as follows.

The Company will pay for Complications of Pregnancy. The Company will pay routine nursery Charges for well baby care for a period of up to five (5) days or until the mother is discharged, (whichever is the lesser period). Coverage for the Policyholder's newborn Child shall become effective as of the Child's date of birth if the Policyholder gives the Company notice by submitting an application or change form to the Company for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid.

OUTPATIENT CARE, is amended by the adding the following notice.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of–Network Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.

OTHER COVERED MEDICAL EXPENSES, IMPORTANCE NOTICE, is hereby amended to add the following paragraph.

> **You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of–Network Provider, refer to the definition of Charge as set out in "DEFINITIONS," Scope of Provider Payment as set out in "OTHER PROVISIONS," and the Schedule of Benefits.**

OTHER COVERED MEDICAL EXPENSES, "Organ Transplant Services" Subsections 8-10 are hereby amended to read as follows.

8. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.

OTHER COVERED MEDICAL EXPENSES, children's preventive health care services, Subsection 4 is hereby amended to read as follows.

> Subject to the Covered Person's payment of the Deductible and the appropriate Coinsurance set forth in the Schedule of Benefits, the Company will pay the percentage set forth on the Schedule of Benefits of Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. Benefits for Evaluation and Management Office Visits and recommended immunization services shall be exempt from any copayment, Coinsurance, Deductible or dollar limit provisions. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

OTHER COVERED MEDICAL EXPENSES, Adult Immunizations is hereby amended to read as follows.

> **Adult Immunizations.** Adult immunizations are generally not covered unless this Policy includes coverage for wellness. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for influenza immunizations for Covered Persons age 18 and older if administered by a Provider whose scope of practice includes administration of vaccines. Influenza immunizations are exempt from any copayment, Deductible or Coinsurance obligations but are limited to the Charge as determined by the Company. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

SERVICES NOT INCLUDED, "Dental Care and Orthodontic Services" is hereby amended to read as follows.

> **Dental Care and Orthodontic Services.** Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:
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> 1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
> 2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.

3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures are generally not covered. However, some services may be covered in accordance with ARTICLE III, C. 11. and ARTICLE IV, A. 2.

SERVICES NOT INCLUDED, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

COORDINATION WITH GROUP COVERAGE, MAJOR MEDICAL COVERAGE AND MEDICARE is hereby amended to read as follows.

If any benefits for services or supplies under this Policy are available to you under any group or blanket disability insurance, Union Welfare Plan, employer or employee benefit organization, self insurance or any other non-regulated group disability benefit plan, individual major medical Policy or no-fault automobile liability insurance, coverages will be coordinated. In other words, benefits may not exceed one hundred percent (100%) of eligible benefits under the combined coverages. The order of benefit determination shall be as follows:

A. The coverage of the Policyholder who is the patient is primary.
B. The coverage of your non-employed Spouse who is also the patient is primary.
C. If your dependent other than your Spouse is the patient, the coverage of the parent whose birthday is first in the year is primary.
D. If the birthdays are the same, the coverage with the earliest effective date is primary.
E. If the parents are separated or divorced, the coverage of the parent who has, in fact, assumed financial responsibility for the dependent, is primary.

OTHER PROVISIONS, is hereby amended to add the following provision.

Scope of Provider Payment - Global Payment. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs)

associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
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State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Amendments
Project Name/Number: 2013 General Amendments - Individual/23-2672,23-2673,23-2674,23-2675,23-2676,23-2677,23-2678, 23-2679 1/13

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/01/2012
Comments:	Please see attached.		
Attachment(s):			
Flesch Certifications Forms 2672,2673,2674,2675,2676,2677,2678,2679 1-13.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/01/2012
Bypass Reason:	Not required.		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	11/01/2012
Bypass Reason:	Not required.		

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	11/01/2012
Bypass Reason:	Not required.		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/01/2012
Bypass Reason:	Not PPACA related.		

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

RE: **Arkansas Blue Cross and Blue Shield**
Amendment Nos. 23-2672,23-2673,23-2674,23-2675,23-2676,23-2677,23-2678,23-2679 1/13

FLESCH READING EASE CERTIFICATION

This is to certify that the above referenced documents has achieved a Flesch Reading Ease Score average of 40.6 and complies with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Disability Insurance Policy Language Simplification Act.

Name

Vice President
Title

October 31, 2012
Date